Radiology Compliance Branch
RADIATION PROTECTION SECTION

Division of Health Service Regulation ● N.C. Department of Health and Human Services

BUSINESS APPLICATION

(All X-Ray Facilities and Service Provider Applicants Must Submit this Form to Radiation Protection)

Purpose of this Application Request (Identify Reason for this request)

☐ New Facility, Service Provider or Company pending Registration Planned Open Date of Facility _____

☐ If a Change of Ownership, include the Previous Owner's Name _____ &

the Previous Owner's Registration #: _____

Were units added or deleted upon acquisition? ☐ Yes, change made ☐ No, all X-ray units same and same location

☐ Currently Registered & Moved to New Location: Registration #: _____

☐ Currently Registered & Update Information Only: Registration #: _____

Please indicate change(s) you are requesting in below sections

☐ 1. Business Info. ☐ 2. Financial Owner ☐ 3. Business Mgr. ☐ 4. RSO ☐ 5. Invoice Contact ☐ 6. Leasing Equip.

1. Business Information: *Registration required within 30 days following initial operation of the facility and each X-Ray unit. X-Ray units installed in separate buildings, in vehicles, under a different roof, or under different administrative control require separate registration.*

Legal Business Name: _____ On-site Contact: _____

Facility Physical Address: _____ Phone: (____) _____ Ext: _____

City: _____ State: _____ Zip Code _____ County: _____

Business Days: ☐ M ☐ T ☐ W ☐ Th ☐ F ☐ Sa **Business Hours:** _____ **Closed for Lunch:** _____

Type of Business: Choose an item **Government Status:** Choose an item **Check if this is a ☐ Mobile Facility**

2. Financial Owner (Required): (e.g. *Physician, CEO, or Corporate Officer)* ☐ Check if preferred mailing address

Business Name: _____ **Type of Ownership:** Choose an item

Name of Most Responsible Person: _____ Title / Position: _____

Mail Address: _____ Phone: (_____) _____ Ext: _____

City: _____ State: ____ Zip Code: _____ Email: _____

3. Business Manager: *Individual responsible for on-site general operations, staffing and purchasing equipment (e.g. director of imaging, manager, or office administration).* ☐ Check if same as item #2 above ☐ Check if preferred mailing address

Name of Manager: _____ Title / Position: _____

Mail Address: _____ Phone: (_____) _____ Ext: _____

City: _____ State: _____ Zip Code: _____ Email: _____

4. Individual Responsible for Radiation Protection / Radiation Safety Officer (Required): ☐ Check if same as item #2 above ☐ Check if preferred mailing address

Training and experience of individual responsible for radiation protection must be available for agency review.

Name: _____ Title / Position: _____

Mail Address: _____ Phone: (_____) _____ Ext: _____

City: _____ State: _____ Zip Code: _____ Email: _____

On-site Individual (if different): _____ Phone: (_____) _____ Ext: _____

5. Invoice Contact: Check if person is same as listed above in ☐**#2** ☐**#3** ☐ **#4** or if different, enter information below.

Name: _____ Title / Position: _____

Mail Address: _____ Phone: (_____) _____ Ext: _____

City: _____ State: _____ Zip Code: _____ Email: _____

6. X-ray Facilities/Practices Only:

X-ray equipment registered in your office/practice; which is being used by another practice at this location.

☐ N/A, I do not allow my X-ray equipment(s) registered in my practice to be used by another practice/lessee.

☐ Yes, I do allow another practice and their staff to use my X-ray equipment at this location. **I take responsibility for the other practices inspection compliance, radiation safety program and registration fees.**

☐ Yes, I do allow another practice and their staff to use my X-ray equipment at this location; and **I do not take responsibility for the other practices inspection compliance and registration fees**. This requires separate registrations for each person using this equipment.

If you are using your X-ray equipment and allowing another practice and their staff to use your X-ray equipment at this one location, enter each practice or lessee(s) contact information to include:
Contact name, practice name, email, phone numbers, address, and work days/hours at your office.

_____

_____

_____

7. Service Company Only:

☐ I do not have X-ray equipment(s) used at the business physical location.

☐ Yes, I have X-ray equipment(s) used at the business physical location for training or demonstration purposes.

☐ I do not have X-ray equipment(s) used by other practice(s), lessee or company.

☐ Yes, I have X-ray equipment used by other practice(s), lessee, or company. **I take responsibility for their inspection compliance, radiation safety program and registration fees.**

☐ Yes, I have X-ray equipment used by other practice(s), lessee, or company; and **I do not take responsibility for their inspection compliance and registration fees**. This requires separate registrations for each person using this equipment.

If the business is acting as a lessor or doing equipment demonstrations, complete a Leasing Company Mobile Equipment Report Form initially. In addition, for equipment coming from out of state, the form must be submitted 5 DAYS PRIOR to the initiation of work.

Send the completed report to XrayService@dhhs.nc.gov.

8. THE LEGAL OWNER OR AUTHORIZED DESIGNEE MUST SIGN AND CERTIFY ALL INFORMATION CONTAINED WITHIN THIS APPLICATION IS ACCURATE AND COMPLETE:

Print Name: _____ Title: _____ Date: _____

Signature: _____

Electronic Signature Agreement: By Clicking the acknowledge checkbox, you are signing this electronically, as your name appears in Print Name (Section 7). You also agree that you have had an opportunity to review the entire application before clicking the acknowledge checkbox. You agree your electronic signature is the legal equivalent of your manual signature.
You also agree that no certification authority or other third party verification is necessary to validate your Electronic Signature and that the lack of such certification or third party verification will not in any way affect the enforceability of your Electronic Signature. You agree and understand that this electronic document may be used in ways similar to how paper documents are used.

☐ **I verify that by checking this box, I am electronically signing my signature to this application which has been verified to be accurate and true.**

9. Equipment Registration Forms: *Any Equipment Changes to Existing Registrations can be made on the* ***Facility Notice of Registration or Deleted Unit Form.***

Check Each Form Included with this Application for a new facility or relocation of existing registered facility:

☐ Healing Arts (Human / Animal use) ☐ Non-Healing Arts (Non-Human/ Non-Animal use) ☐ Therapy ☐ Mammography

☐ Deleted Units ☐ Service Provider

Submit the completed application to XrayNORS@dhhs.nc.gov.